BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Dominic Kam-Yin Ho, M.D. Physician's and Surgeon's Certificate No. G 52943 Respondent.	Case No. 800-2019-052541

DECISION

The attached Stipulated Surrender of License and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 31, 2023.

IT IS SO ORDERED December 21, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka, Executive Director

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
CHRISTINE A. RHEE
Deputy Attorney General
State Bar No. 295656
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9455
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DOMINIC KAM-YIN HO, M.D.** **101 S. San Mateo Dr., Ste. 302** **San Mateo, CA 94401-3844** **Physician's and Surgeon's Certificate No. G 52943,** Respondent.	Case No. 800-2019-052541 OAH No. 2022040789 **STIPULATED SURRENDER OF LICENSE AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Christine A. Rhee, Deputy Attorney General.

///

///

2. Dominic Kam-Yin Ho, M.D. (Respondent), is represented in this proceeding by attorneys James M. Goodman, Esq., and Warren R. Webster, Esq., whose address is: 275 Battery Street, Suite 1600, San Francisco, CA 94111-3370.

3. On or about July 9, 1984, the Board issued Physician's and Surgeon's Certificate No. G 52943 to Respondent. Physician's and Surgeon's Certificate No. G 52943 was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2019-052541 and will expire on May 31, 2024, unless renewed.

JURISDICTION

4. Accusation No. 800-2019-052541 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on February 3, 2022. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2019-052541 is attached as Exhibit A and incorporated by reference herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-052541. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Having had the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

///

///

CULPABILITY

8. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2019-052541, and that he has thereby subjected his license to disciplinary action.

9. Respondent agrees that if he ever petitions for reinstatement of his license, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations in Accusation No. 800-2019-052541 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

10. Respondent understands that by signing this stipulation he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. Pursuant to Business and Professions Code section 2224, subdivision (b), the Executive Director of the Board has been delegated the authority to adopt or reject a stipulation for surrender of a Physician's or Surgeon's Certificate.

12. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved by the Executive Director on behalf of the Board. Respondent fully understands and agrees that in deciding whether or not to approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive Director and/or the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Executive Director, the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving Respondent. In the event that the Executive Director on behalf of the Board does not, in his discretion, approve and adopt this Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees

that should this Stipulated Surrender and Disciplinary Order be rejected for any reason by the Executive Director on behalf of the Board, Respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion, and/or consideration of this Stipulated Surrender of License and Disciplinary Order or of any matter or matters related hereto.

13. The Executive Director shall have a reasonable period of time in which to consider and act upon this stipulation after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director considers and acts upon it.

ADDITIONAL PROVISIONS

14. This Stipulated Surrender and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final, and exclusive embodiment of the agreements of the parties in the above-listed matter.

15. The parties agree that copies of this Stipulated Surrender and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 52943, issued to Respondent Dominic Kam-Yin Ho, M.D., is surrendered effective March 31, 2023, and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a physician and surgeon in California as of the effective date of the Board's Decision and Order, which shall be March 31, 2023.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2019-052541 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $22,597.50 prior to issuance of a new or reinstated license.

6. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2019-052541 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Disciplinary Order and have fully discussed it with my attorneys, James M. Goodman, Esq., and Warren R. Webster, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: Dec 1, 2022

DOMINIC K HO
DOMINIC K HO (Dec 1, 2022 14:53 PST)

DOMINIC KAM-YIN HO, M.D.
Respondent

///

///

///

I have read and fully discussed with Respondent Dominic Kam-Yin Ho, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 12/1/2022

JAMES M. GOODMAN, ESQ.
WARREN R. WEBSTER, ESQ.
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

SF2022400092
83692560.docx

I have read and fully discussed with Respondent Dominic Kam-Yin Ho, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: _____

JAMES M. GOODMAN, ESQ.
WARREN R. WEBSTER, ESQ.
Attorneys for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: December 1, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

CHRISTINE A. RHEE
Deputy Attorney General
Attorneys for Complainant

SF2022400092
83692560.docx

Exhibit A

Accusation No. 800-2019-052541

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
CHRISTINE A. RHEE
Deputy Attorney General
State Bar No. 295656
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9455
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DOMINIC KAM-YIN HO, M.D.** **101 S. San Mateo Dr., Ste. 302** **San Mateo, CA 94401-3844** **Physician's and Surgeon's Certificate No. G 52943,** Respondent.	Case No. 800-2019-052541 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 9, 1984, the Board issued Physician's and Surgeon's Certificate No. G 52943 to Dominic Kam-Yin Ho, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2022, unless renewed.

///

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states, in pertinent part:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> ...

5. Section 2234 of the Code, states, in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> ...
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
>
> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but

not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

...

6. Section 2266 of the Code states that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

COST RECOVERY

7. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any

licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE
(Gross Negligence)

8. Respondent has subjected his Physician's and Surgeon's Certificate No. G 52943 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients A, B, C, and D,[1] as more particularly alleged hereafter:

Patient A

9. On or about April 17, 2015, Patient A, then a morbidly obese 46-year-old female, presented to Respondent, a solo practitioner specializing in internal medicine. Respondent documented that Patient A had moderate low back pain and previously had back surgery for a herniated disc. He documented that Patient A was currently taking methadone,[2] but did not document whether it was for pain or for opioid use disorder maintenance therapy. Respondent also did not document a pain evaluation or substance abuse history. Patient A told Respondent that she was going to see a pain specialist soon. Respondent documented that he refilled Patient A's medication, but failed to document what those medications were.

///

///

[1] Names of the patients have been omitted to protect their privacy.

[2] Methadone, brand name Methadose, is an opioid use to treat moderate to severe pain or opioid addiction. Methadone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c).

10. According to CURES,[3] from on or about April 17, 2015 through December 1, 2015, Patient A filled approximately monthly prescriptions written by Respondent for 240 tablets of 10 mg methadone.

11. Respondent's medical records for Patient A include a hospital visit on or about April 6, 2015. In that visit, Patient A complained of sudden onset chest pain and an inability to breathe. Patient A reported that she was trying to discontinue her medications, including methadone and tramadol,[4] and that she had been off her medications for about a week.

12. On or about June 2, 2015, Patient A returned to Respondent's office and complained of lower back pain and anxiety. Respondent gave Patient A a new prescription for alprazolam.[5] Respondent failed to document any evaluation of Patient A's symptoms or a discussion with Patient A regarding the risks of concurrent opioid and benzodiazepine use.

13. According to CURES, from on or about June 2, 2015 through July 3, 2015, Patient A filled three prescriptions written by Respondent, each for 30 tablets of 0.5 mg alprazolam. On or about July 27, 2015, Patient A filled a prescription written by Respondent for 10 tablets of 0.5 mg alprazolam.

14. According to CURES, on or about July 31, 2015 and August 27, 2015, Patient A filled prescriptions written by H.L., M.D., each for 90 tablets of 50 mg tramadol. On or about August 16, 2015, Patient A filled a prescription written by T.D., M.D., for 15 tablets of 325-5 mg hydrocodone acetaminophen.[6]

15. Patient A returned to Respondent's office for monthly visits from June through October 2015. Respondent's records for these visits make no reference to the prescriptions written by the other treatment providers. Respondent did not document any monitoring of Patient

[3] The Controlled Substance Utilization Review and Evaluation System (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement.

[4] Tramadol is an opioid analgesic and a Schedule IV controlled substance pursuant to the Controlled Substances Act.

[5] Alprazolam, brand name Xanax, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

[6] Norco and Vicodin are the brand names for hydrocodone acetaminophen. Hydrocodone is an opioid pain reliever and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

A's controlled substance medications. According to CURES, on or about October 2, 2015, Patient A filled two prescriptions written by Respondent for 30 tablets of 0.5 mg alprazolam and 240 tablets of 10 mg methadone.

16. According to CURES, on or about October 24, 2015, Patient A filled a prescription written by T.D., M.D., for 15 tablets of 5 mg diazepam.[7]

17. At a visit on or about December 1, 2015, Patient A told Respondent that she wanted to decrease her methadone dose. Respondent's plan was to decrease Patient A's methadone at her next appointment.

18. On or about December 28, 2015, Respondent issued a prescription for 210 tablets of 10 mg methadone, which Patient A filled on or about the same day.

19. On or about January 20, 2016, Patient A went to the hospital for worsening anxiety and increased breathing. Patient A told treatment providers there that she had tried to see her primary care physician but the doctor who was on call did not accept her insurance. Patient A reported that she had last taken Xanax in October 2015, and that she was trying to discontinue all of her medications. Treatment providers determined that she had a panic attack and gave her a prescription for 15 tablets of 0.25 alprazolam.

20. On or about January 22, 2016, Patient A saw Respondent in his office. Respondent's notes for this visit fail to address Patient A's hospital visit, other than stating that she was complaining of anxiety. Respondent re-started Patient A on monthly prescriptions of 30 tablets of 0.25 mg alprazolam.

21. According to CURES, from on or about January 22, 2016 through April 15, 2016, Patient A filled four prescriptions written by Respondent, each for 210 tablets of 10 mg methadone. During that same period of time, Patient A filled two additional prescriptions written by Respondent for 30 tablets of 0.5 mg alprazolam.

22. On or about April 29, 2016, Patient A asked Respondent for an early refill of her medications because she was going out of town. On or about the same day, she filled

[7] Diazepam, brand name Valium, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

prescriptions written by Respondent for 210 tablets of 10 mg methadone and 30 tablets of 0.5 alprazolam.

23. According to CURES, on or about May 27, 2016, Patient A filled a prescription written by J.H., M.D., for 210 tablets of 10 mg methadone.

24. On or about June 17, 2016, Patient A saw Respondent in his office. Respondent noted that Patient A was doing well. He reduced Patient A's methadone use to 30 mg per day, or 180 tablets per month. According to CURES, on or about June 20, 2016 and July 13, 2016, Patient A filled prescriptions for 180 tablets of 10 mg methadone and 30 tablets of 0.5 mg alprazolam.

25. On or about August 3, 2016, Patient A again told Respondent that she was going out of town and requested an early refill. Respondent documented that he refilled her medications, but did not specify which ones.

26. On or about August 10, 2016, Patient A saw Respondent and reported that the pharmacy only gave her 90 tablets of methadone on or about August 3, 2016. Patient A requested an additional 90 tablets and another monthly alprazolam prescription. Once again, Respondent documented that he refilled her medications, but did not specify which ones.

27. According to CURES, Patient A did not fill a prescription on or about August 3, 2016 for 90 tablets of 10 mg methadone. Instead, CURES shows that on or about August 10, 2016, Patient A filled three prescriptions written by Respondent: (1) 100 tablets of 10 mg methadone; (2) 90 tablets of 10 mg methadone; and (3) 30 tablets of 0.5 mg alprazolam.

28. On or about August 24, 2016, Patient A saw Respondent at his office. Patient A told Respondent that she was not able to fill the last prescription for 90 tablets of methadone because the pharmacy was out of stock and that she consequently needed another refill. Respondent gave her a refill for 180 tablets of 10 mg methadone. According to CURES, Patient A filled that prescription for 180 tablets on or about the same day.

29. On or about September 12, 2016, Patient A saw Respondent at his office. At this visit, Patient A claimed that she was only given 90 tablets of methadone on or about August 24, 2016, and therefore needed another methadone prescription. Respondent gave Patient A another

prescription for 180 tablets of 10 mg methadone. According to CURES, Patient A filled that prescription on or about the same day.

30. On or about September 25, 2016, Respondent documented that he gave Patient A a prescription for 14 tablets of 0.5 mg alprazolam. According to CURES, on or about September 29, 2016, Patient A filled a prescription for 15 tablets of 0.5 mg alprazolam.

31. According to CURES, from on or about October 3, 2016 through February 10, 2017, Patient A filled approximately seven (7) prescriptions written by J.H., M.D., each for 210 tablets of 10 mg methadone, and approximately four (4) prescriptions written by J.H., M.D., each for 30 tablets of 0.5 mg alprazolam.

32. On or about March 6, 2017, Patient A returned to Respondent's office for treatment. Respondent noted that Patient A had been seeing another physician and had been receiving 210 tablets of 10 mg methadone a month. Respondent gave Patient A a prescription for 180 tablets of 10 mg methadone, which Patient A filled on or about March 7, 2017.

33. On or about March 28, 2017, Patient A saw Respondent and asked for an early refill for methadone because she was going out of town from approximately March 31, 2017 through April 15, 2017. Respondent gave Patient A a prescription for 90 tablets of 10 mg methadone, which Patient A filled on or about the same day.

34. On or about April 13, 2017, Patient A saw Respondent at his office. Respondent documented that he gave Patient A a prescription for 180 tablets of 10 mg methadone, which Patient A filled on or about the same day.

35. According to CURES, on or about May 19, 2017, Patient A filled a prescription written by I.K., M.D., for 16 tablets of 325-5 mg hydrocodone acetaminophen.

36. On or about May 24, 2017, Patient A returned to Respondent's office for an annual history and physical. Respondent failed to document any information regarding Patient A's significant opioid use other than documenting that Patient A was on "methadone maintenance."

37. According to CURES, on or about May 24, 2017 and June 21, 2017, Patient A filled prescriptions written by Respondent, each for 180 tablets of 10 mg methadone.

///

38. Respondent committed gross negligence in his care and treatment of Patient A which includes, but is not limited to, the following:

a. Respondent failed to properly evaluate and treat Patient A's chronic pain using non-opiate management;

b. Respondent failed to properly manage and/or monitor Patient A's methadone therapy; and

c. Respondent failed to properly manage and/or treat Patient A's anxiety.

Patient B

39. Respondent began treating Patient B in approximately May 2005[8] as Patient B's primary care practitioner. From in or around May 2005 through February 2015, Respondent treated Patient B's anxiety with various benzodiazepine medications including alprazolam, diazepam, and clonazepam.[9] During that period of time, starting in or around February 2011, Respondent also treated Patient B's menstrual, ankle, and knee pain[10] with hydrocodone acetaminophen.

40. On or about January 27, 2010, police officers took Patient B to a hospital for treatment. Patient B was requesting to detox from the substances she was taking, including diazepam and hydrocodone acetaminophen. At the hospital, Patient B's urine tested positive for alcohol, benzodiazepines, and cocaine. Patient B reported that she was drinking and blacking out every weekend, taking hydrocodone acetaminophen for hangovers, and taking diazepam for anxiety. At the end of the visit, Patient B declined inpatient detox treatment and was discharged. Respondent's medical records fail to reflect this hospital visit or any evaluation of Patient B's substance abuse history.

---

[8] Conduct occurring more than seven (7) years from the filing date of this Accusation or more than three (3) years from notification to the Board is for informational purposes only and is not alleged as a basis for disciplinary action.

[9] Clonazepam, brand name Klonopin, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

[10] At a visit on or about September 29, 2011, Patient B complained of right ankle pain. Respondent noted that the ankle pain was "from a previous injury," and prescribed hydrocodone acetaminophen for right ankle and pre-menstrual syndrome pain. At an interview with Board investigators, Respondent stated that Patient B had broken her right ankle in a motor vehicle accident, and was prescribed 10 mg Norco twice per day. This information that Patient B had been in a car accident was finally referenced in a medical record on or about May 7, 2014.

41. By in or around February 2015, Respondent was treating Patient B with a monthly regimen of 60 tablets of 325-10 mg hydrocodone acetaminophen and 30 tablets of 2 mg alprazolam.

42. On or about March 19, 2015, Patient B, then a 30-year-old female, saw Respondent in his office. Respondent noted that Patient B had right ankle pain. At no point during Respondent's treatment of Patient B did Respondent ever order or perform further work-up to investigate Patient B's ankle pain.

43. On or about May 21, 2015, Patient B, saw Respondent in his office. Respondent documented that Patient B had a history of anxiety and chronic right ankle pain. Respondent documented that Patient B was being followed by an orthopedist who advised against surgery, and that Patient B had tried injections and physical therapy. Patient B had also tried Tylenol #4[11] and ibuprofen.[12] Respondent documented that he gave Patient B prescriptions for 60 tablets of 325-10 mg hydrocodone acetaminophen and 60 tablets of 2 mg alprazolam, which Patient B filled on or about the same day. Respondent failed to document his rationale for doubling Patient B's alprazolam dose.

44. According to CURES, from on or about June 25, 2015 through December 1, 2015, Patient B filled approximately four (4) prescriptions written by Respondent for 60 tablets of 325-10 mg hydrocodone acetaminophen, and approximately three (3) prescriptions for 60 tablets of 2 mg alprazolam.

45. According to CURES, on or about December 1, 2015, Patient B filled a prescription written by Respondent for 60 tablets of 2 mg clonazepam. Respondent failed to document why he switched Patient B from alprazolam to clonazepam.

///

///

[11] Tylenol Codeine No. 4 contains 300 mg of acetaminophen and 60 mg of codeine. Codeine is an opiate and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b). In a note dated May 7, 2014, Respondent documented that Patient B could not take Tylenol because she had a history of gastritis. Respondent then gave Patient B a prescription for 325-10 mg hydrocodone acetaminophen.

[12] Ibuprofen, brand name Advil or Motrin, is a non-steroidal anti-inflammatory drug (NSAID).

46. According to CURES, on or about January 5, 2016, Patient B filled prescriptions written by Respondent for 60 tablets of 325-10 mg hydrocodone acetaminophen, and 60 tablets of 2 mg clonazepam.

47. According to CURES, on or about February 3, 2016, Patient B filled prescriptions written by Respondent for 60 tablets of 325-10 mg hydrocodone acetaminophen, and 60 tablets of 10 mg diazepam. Respondent failed to document his rationale for switching Patient B from clonazepam to diazepam.

48. According to CURES, from on or about March 4, 2016 through May 2, 2016, Patient B filled two (2) prescriptions written by Respondent, each for 60 tablets of 325-10 mg hydrocodone acetaminophen, and two (2) prescriptions written by Respondent, each for 60 tablets of 10 mg diazepam.

49. On or about June 13, 2016, Patient B saw Respondent in his office. Respondent documented that Patient B had moderate right ankle pain and that her anxiety was stable. He noted that he refilled Patient B's medications and "discussed rehab."

50. According to CURES, on or about June 13, 2016, Patient B filled a prescription written by Respondent for 60 tablets of 325-7.5 mg hydrocodone acetaminophen and 60 tablets of 10 mg diazepam. Respondent failed to document his rationale for lowering Patient B's hydrocodone acetaminophen dose.

51. On or about July 12, 2016, Patient B saw Respondent for a follow-up appointment. Respondent documented that he gave Patient B a prescription for 325-10 mg hydrocodone acetaminophen and gave her a new prescription for 60 tablets of 2 mg clonazepam. According to CURES, Patient B filled these prescriptions on or about July 13, 2016. Respondent failed to document his rationale for increasing Patient B's hydrocodone dose and switching Patient B's benzodiazepine medication from diazepam to clonazepam.

52. According to CURES, on or about August 24, 2016, Patient B filled prescriptions written by Respondent for 60 tablets of 325-10 mg hydrocodone acetaminophen and 60 tablets of 2 mg alprazolam. Respondent failed to document his rationale for switching Patient B's benzodiazepine medication from clonazepam to alprazolam.

53. According to CURES, from on or about September 20, 2016 through December 19, 2016, Patient B filled approximately monthly prescriptions written by Respondent for hydrocodone acetaminophen and alprazolam.

54. On or about September 21, 2016, Respondent documented that he spoke to Patient B about her dependency on Norco. He recommended that Patient B go to a pain clinic for an evaluation or a detox program.

55. On or about February 2, 2017, Patient B saw Respondent and reported that she had been in a car accident in the past month. Patient B complained of neck pain. Respondent did no further work-up other than a physical exam.

56. According to CURES, between on or about February 2, 2017 and June 1, 2017, Patient B filled approximately five (5) prescriptions written by Respondent for 60 tablets of 325-10 mg hydrocodone acetaminophen and six (6) prescriptions for 60 tablets of 2 mg alprazolam.

57. On or about June 26, 2017, Respondent received a notification that Patient B had gone to the hospital the same day for a near syncope. According to the hospital's records, Patient B reported that she was detoxing from heroin and alprazolam. She told treatment providers that she had a history of methamphetamine, heroin, and alprazolam abuse. Patient B was given a prescription for zolpidem tartrate[13] and advised to follow up with Respondent.

58. On or about August 29, 2017, Patient B saw Respondent in his office. Patient B complained of moderate right ankle pain. Respondent did not document any discussion with Patient B about her June 26, 2017, hospitalization. Respondent noted that he refilled Patient B's medications.

59. According to CURES, on or about August 29, 2017, Patient B filled two prescriptions written by Respondent for 60 tablets of 325-10 mg hydrocodone acetaminophen and 60 tablets of 2 mg alprazolam.

///

///

[13] Zolpidem tartrate, brand name Ambien, is a sedative hypnotic and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

60. On or about September 27, 2017, Patient B saw Respondent in his office to refill her medications. Respondent documented that Patient B was stable and that he would refer her to rehab.

61. According to CURES, on or about September 27, 2017 and October 30, 2017, Patient B refilled her prescriptions written by Respondent for hydrocodone acetaminophen and alprazolam.

62. On or about November 10, 2017, Respondent documented that Patient B was to enter a rehab program for opioid dependency. His medical records include a letter dated on or about November 20, 2017, from the rehabilitation program, saying that Patient B entered the program on or about November 6, 2017, and was expected to complete the program on or about February 4, 2018.

63. According to CURES, on or about November 20, 2017 and December 20, 2017, Patient B filled prescriptions written by Respondent for 60 tablets of 2 mg alprazolam.

64. On or about January 5, 2018, Patient B saw D.H., M.D., to establish care. Patient B reported that she first started taking opioids in 2012, which progressed to smoking heroin in 2014 to injecting heroin in 2016. Patient B also reported that she had been taking benzodiazepines for approximately 10 years, and saw Respondent for monthly alprazolam prescriptions. D.H., M.D., diagnosed Patient B with severe opioid dependence and social anxiety disorder.

65. On or about January 19, 2018, Patient B saw Respondent in his office. Respondent noted that Patient B had "quit Norco" and that he refilled her medications. Respondent's record for this visit did not reference Patient B's treatment with D.H., M.D.

66. According to CURES, on or about January 19, 2018 and February 20, 2018, Patient B filled prescriptions written by Respondent for 60 tablets of 2 mg alprazolam.

67. On or about August 27, 2018, Patient B saw Respondent in his office. Patient B reported that she had weaned off opioids and alprazolam and was doing well.

///

///

///

68. Respondent committed gross negligence in his care and treatment of Patient B which includes, but is not limited to, the following:

a. Respondent failed to adequately evaluate and monitor Patient B's opiate therapy; and

b. Respondent failed to properly manage Patient B's treatment for anxiety.

Patient C

69. From on or about May 24, 2013 through January 9, 2015, Respondent treated Patient C by prescribing phendimetrazine tartrate,[14] liquid methadone, alprazolam, and lorazepam.[15]

70. On or about January 26, 2015, Patient C, then a 37-year-old female, saw Respondent in his office. Respondent documented that Patient C had a history of anxiety, hypertension, and high cholesterol. Respondent gave Patient C a prescription for 60 tablets of 1 mg lorazepam, which Patient C filled on or about the same day.

71. On or about February 16, 2015, Patient C told Respondent that she was going out of town for approximately three weeks and that she needed early refills on her medications. Respondent documented that he gave her refills, but he did not specifically which ones.

72. According to CURES, on or about February 16, 2015, Patient C filled a prescription written by Respondent for 60 tablets of 1 mg lorazepam. On or about March 11, 2015, Patient C filled a prescription written by Respondent for 460 mL of 10 mg/1 mL methadone. On or about March 11, 2015, Patient C also filled a prescription written by K.C., D.D.S., for 16 tablets of 325-5 mg oxycodone acetaminophen.[16]

73. On or about May 4, 2015, Patient C saw Respondent in his office. Patient C needed medication refills. Respondent documented that he gave Patient C a prescription for 50 tablets of 2 mg lorazepam, which Patient C filled on or about the same day. Respondent failed to document his rationale for increasing Patient C's lorazepam dose.

---

[14] Phendimetrazine tartrate is an anorectic used to promote weight loss.

[15] Lorazepam, brand name Ativan, is a benzodiazepine and a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d).

[16] Oxycodone acetaminophen, brand name Percocet, is an opioid pain reliever. Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b).

74. On or about June 4, 2015, Respondent performed a history and physical on Patient C. Respondent documented that Patient C was on methadone maintenance and that she had anxiety, hypertension, and high cholesterol.

75. According to CURES, on or about June 6, 2015, Patient C filled two prescriptions written by Respondent for 460 mL of 10 mg/1 mL methadone and 50 tablets of 2 mg lorazepam.

76. On or about July 17, 2015, Respondent gave Patient C prescriptions for methadone and lorazepam. According to CURES, on or about July 18, 2015, Patient C filled these prescriptions for 460 mL of 10 mg/1 mL methadone and 60 tablets of 1 mg lorazepam. Respondent failed to document his rationale for decreasing Patient C's lorazepam dose.

77. On or about August 27, 2015, Respondent gave Patient C prescriptions for methadone and lorazepam. According to CURES, on or about August 28, 2015, Patient C filled these prescriptions for 420 mL of 10 mg/1 mL methadone and 60 tablets of 2 mg lorazepam. Respondent failed to document his rationale for decreasing Patient C's methadone dose and increasing Patient C's lorazepam dose.

78. In or around October 2015, Respondent refilled Patient C's methadone and lorazepam prescriptions. At an appointment on or about November 13, 2015, Respondent documented that he gave Patient C prescriptions for methadone and 30 tablets of 2 mg lorazepam. Respondent failed to document his rationale for decreasing Patient C's lorazepam dose.

79. On or about January 28, 2016, Patient C saw Respondent in his office. Respondent noted that he refilled Patient C's medications without listing the medications by name. According to CURES, on or about January 28, 2016, Patient C filled a prescription written by Respondent for 300 mL of 10 mg/1 mL methadone, and on or about February 2, 2016, Patient C filled a prescription written by Respondent for 60 tablets of 2 mg lorazepam. Respondent failed to document his rationale for decreasing Patient C's methadone dose and increased Patient C's lorazepam dose.

80. According to CURES, on or about January 29, 2016, Patient C filled a prescription written by Respondent for 14 tablets of 1 mg lorazepam from D.L.

///

81. According to CURES, on or about February 26, 2016 and February 29, 2016, Patient C filled two prescriptions written by Respondent for methadone, the first for 300 mL and the second for 160 mL. Respondent failed to document why he increased Patient C's methadone dose.

82. On or about March 29, 2016, Patient C saw Respondent in his office. For this visit, Respondent documented that he was decreasing Patient C's methadone with instructions that she take ½ of a teaspoon in the morning and one teaspoon in the afternoon. Respondent also inaccurately documented that he gave Patient C a prescription for alprazolam.

83. According to CURES, on or about March 29, 2016, Patient C filled a prescription written by Respondent for 60 tablets of 2 mg lorazepam. Contrary to his note on or about March 29, 2016, Patient C filled a prescription written by Respondent for 460 mL of 10 mg/1 mL methadone on or about on or about April 19, 2016.

84. From on or about May 3, 2016 through June 5, 2017, Respondent continued to see Patient C and prescribe 460 mL of 10 mg/1 mL methadone and 60 tablets of 2 mg lorazepam approximately every month. During this period of time, Patient C started physical therapy for pain in her left ankle, left knee, and hip.

85. According to CURES, on or about June 24, 2017, Patient C filled a prescription written by Respondent for 90 tablets of 2 mg lorazepam. Respondent failed to document his rationale for increasing Patient C's lorazepam dose.

86. From on or about July 31, 2017 through September 8, 2017, Respondent continued to see Patient C and prescribe 460 mL of 10 mg/1 mL methadone and 90 tablets of 2 mg lorazepam approximately every month.

87. On or about October 11, 2017, Patient C told Respondent that she was moving and needed early refills. Respondent documented that he refilled her medications.

88. According to CURES, on or about October 13, 2017, Patient C filled prescriptions from Respondent for 460 mL of 10 mg/1 mL methadone and 60 tablets of 2 mg lorazepam.

///

///

89. On or about November 20, 2017, Patient C went to the hospital for opiate withdrawal symptoms, including nausea and diarrhea. Patient C reported that she last took methadone a week prior, and that she had been unable to refill her methadone prescription because Respondent was on vacation and his covering physician refused to fill her prescription. Respondent's covering physician eventually agreed to write a prescription for 120 mL of 10 mg/1 mL methadone.

90. On or about November 29, 2017, Patient C saw Respondent in his office. Respondent documented that Patient C was not moving and therefore needed refills on her medications.

91. From on or about November 29, 2017 through January 26, 2019, Respondent continued to see Patient C and prescribe 460 mL of 10 mg/1 mL methadone and varying amounts of 2 mg lorazepam, ranging from 60 to 104 tablets per prescription. Respondent failed to document his rationale for changing Patient C's lorazepam dose.

92. On or about March 15, 2019, Patient C saw Respondent in his office. Respondent documented that he gave Patient C a prescription for 400 mL of methadone. Respondent also erroneously documented that he gave Patient C a prescription for 88 tablets of 2 mg alprazolam, rather than lorazepam. According to CURES, Patient C filled the methadone prescription and prescription for 88 tablets of 2 mg lorazepam on or about March 17, 2019.

93. From on or about May 1, 2019 through July 1, 2020, Respondent continued to see Patient C and prescribe 400 mL of 10 mg/1 mL methadone and varying amounts of 1 or 2 mg lorazepam, ranging from 30 to 150 tablets per prescription. Respondent failed to document his rationale for changing Patient C's lorazepam dose.

94. At a visit on or about July 10, 2020, Respondent decreased Patient C's lorazepam prescription to 60 tablets and decreased Patient C's methadone prescription to 230 mL.

95. From on or about July 10, 2020 through April 23, 2021, Respondent continued to see Patient C and prescribe decreasing doses of methadone and lorazepam. At a visit on or about May 21, 2021, Respondent noted that Patient C had stopped taking lorazepam.

96. Respondent committed gross negligence in his care and treatment of Patient C which includes, but is not limited to, the following:

///

a. Respondent failed to properly evaluate and care for Patient C's chronic pain using non-opiate management.

Patient D

97. On or about March 25, 2017, Patient D, then a 62-year-old female, saw Respondent for a history and physical. Respondent documented that Patient D had a history of anxiety, irritable bowel syndrome (IBS), and depression. Her current medications included but were not limited to sertraline,[17] lorazepam, and suvorexant.[18] Respondent also noted that Patient D did not drink alcohol or smoke tobacco.

98. According to CURES, from on or about September 1, 2017 through October 6, 2017, Patient D filled four (4) prescriptions written by Respondent, two (2) for 30 tablets of 1 mg alprazolam and two (2) for 30 tablets of 20 mg suvorexant.

99. On or about October 24, 2017, Patient D saw Respondent for medication refills. Respondent gave Patient D a prescription for 35 tablets of 1 mg alprazolam, which Patient D filled on about the same day. Respondent failed to document his rationale for prescribing more alprazolam.

100. According to CURES, on or about October 25, 2017, Patient D filled a prescription written by S.R., M.D., for 25 tablets of 1 mg lorazepam.

101. On or about November 7, 2017, Patient D saw Respondent in his office. She reported that the suvorexant was not working for her insomnia, and that she wanted to take a higher dose. Respondent noted that Patient D was already taking suvorexant at the maximum recommended dose. He gave Patient D a refill of the medication, despite the fact that Patient D told him it was ineffective.

102. According to CURES, on or about November 22, 2017, Patient D filled a prescription written by R.D., M.D., for 16 tablets of 4 mg hydromorphone.[19]

///

[17] Sertraline, brand name Zoloft, is an anti-depressant.

[18] Suvorexant, brand name Belsomra, is a Schedule IV controlled substance pursuant to the Controlled Substances Act.

[19] Hydromorphone, brand name Dilaudid, is an opioid and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)

103. At a visit with Respondent on or about November 27, 2017, Patient D reported that she had gone to the hospital the week prior. Patient D said she had fallen and had rib pain. Respondent documented that Patient D had been prescribed hydrocodone acetaminophen to treat the pain and that Patient D wanted a refill. Respondent gave Patient D prescriptions for 14 tablets of 325-5 mg hydrocodone acetaminophen and 30 tablets of 1 mg alprazolam, which Patient D filled on or about the same day.

104. On or about November 30, 2017, Patient D went to the emergency department and requested hydromorphone. The treatment providers at the hospital noted that Patient D had a history of opiate abuse and dependence, and that she was last treated in July after Patient D fell and sustained multiple left-sided fractures. Patient D's pertinent medical history listed Hepatitis C, opiate dependence, and tobacco dependence. Her current medications included hydromorphone, clonazepam, and Suboxone.[20] Her treatment provider at the hospital did not provide Patient D with any medication and noted the following:

> [p]atient has overtaken medications in the past and I do not feel it is safe to refill a narcotic or sedative medication to her again (see visit 7/21, patient not given narcotics then as overdosed that day and went to detox after her subacute rib fractures). Patient is high risk for overdose. She had declined tramadol from her [primary care provider], discussed trial of naproxen[21] and tramadol together, Lidoderm[22] patch and follow up with her PCP.

Respondent's medical records included the medical records documenting this hospital visit.

105. According to CURES, on or about November 30, 2017, Patient D filled a prescription written by E.G., M.D., for 10 tablets of 50 mg tramadol and another prescription written by S.R., M.D., for 20 tablets of 1 mg lorazepam. On or about December 5, 2017, Patient D filled a prescription written by Respondent for 30 tablets of 20 mg suvorexant.

106. On or about December 12, 2017, Patient D went to the emergency department for left knee pain. Patient D reported that she had fallen two days prior while walking her dog. At the hospital, x-rays ruled out any fracture or dislocation. Patient D was advised to take Tylenol or

---

[20] Suboxone, the brand name for buprenorphine naloxone, is a medication used to treat opioid use disorder.

[21] Naproxen, brand name Naprosyn, is a NSAID.

[22] Lidoderm, brand name for lidocaine, is an anesthetic.

ibuprofen as needed. Respondent's medical records included the records documenting this hospital visit.

107. On or about December 18, 2017, Patient D saw Respondent in his office. Patient D was requesting refills for alprazolam and hydrocodone acetaminophen. Respondent noted that Patient D had mild left rib pain and that he gave Patient D a prescription for alprazolam. Respondent advised Patient D to take Advil as needed.

108. According to CURES, on or about the same day, Patient D filled a prescription written by Respondent for 30 tablets of 50 mg tramadol. Respondent failed to document this new prescription in his medical records.

109. According to CURES, from on or about December 24, 2017 to December 28, 2017, Patient D filled prescriptions written by Respondent for 30 tablets of 1 mg alprazolam and 20 tablets of 1 mg lorazepam. Respondent failed to document this lorazepam prescription.

110. On or about December 29, 2017, Patient D went to the emergency department again for left knee pain. She requested a Suboxone prescription. Patient D was informed that the hospital did not prescribe Suboxone, and that she needed to see her PCP.

111. According to CURES, on or about December 30, 2017, Patient D filled a prescription written by A.C. for 10 tablets of 50 mg tramadol. Three days later, on or about January 2, 2018, Patient D filled prescriptions written by Respondent for 20 tablets of 50 mg tramadol and 30 tablets of 20 mg suvorexant.

112. On or about January 5, 2018, Patient D saw Respondent in his office. Patient D complained of left knee swelling and reported that she only received 20 tablets of tramadol, despite receiving an additional 10 tablets from another treatment provider on or about December 30, 2017. For the first time in his records, Respondent documented that Patient D had a history of substance abuse. He gave her a prescription for 10 tablets of 50 mg tramadol, as well as a referral to a specialist. Patient D filled the tramadol prescription on or about the same day.

113. On or about January 7, 2018, Patient D went to the emergency department again. She complained of nausea without vomiting or diarrhea. Patient D told her treatment providers that she had recently been prescribed Naprosyn at the hospital and that she believed the medication

was causing her pain. Patient D's physical examination was normal and Patient D was given non-narcotic medication to treat her nausea.

114. According to CURES, Patient D filled the following prescriptions from other treatment providers: (1) 30 sublingual films of 8-2 mg Suboxone from N.K., M.D., on or about January 9, 2018; (2) 14 tablets of 1 mg alprazolam from N.K., M.D., on or about January 9, 2018; (3) 60 tablets of 325-5 mg hydrocodone acetaminophen from A.B., M.D., on or about January 11, 2018; (4) 30 tablets of 10 mg alprazolam from W.H., D.D.S., on or about January 22, 2018; and (5) 30 sublingual films of 8-2 mg Suboxone from N.K., M.D., on or about February 6, 2018.

115. On or about February 21, 2018, Patient D saw Respondent in his office. Respondent noted that Patient D was stable and needed medication refills. On or about the same day, Patient D filled prescriptions written by Respondent for 30 tablets of 1 mg alprazolam and 30 tablets of 20 mg suvorexant.

116. According to CURES, from on or about March 3, 2018 through October 19, 2018, Patient D filled approximately 14 prescriptions written by K.G, N.P., for Suboxone. In his records during this time period, Respondent never documented that Patient D's current medications included Suboxone or that Patient D was seeing other treatment providers.

117. According to CURES, from on or about March 3, 2018 through October 19, 2018, Patient D continued to fill prescriptions written by Respondent for alprazolam and suvorexant.

118. According to CURES, from on or about March 3, 2018 through October 19, 2018, Patient D also filled the following prescriptions from other treatment providers: (1) 25 tablets of 1 mg lorazepam from S.R., M.D., on or about March 30, 2018; (2) 30 tablets of 1 mg lorazepam from S.R., M.D., on or about July 10, 2018; (3) 20 tablets of 325-5 mg hydrocodone acetaminophen from A.R., D.D.S., on or about August 1, 2018; (4) 20 tablets of 325-5 mg hydrocodone acetaminophen from A.R., D.D.S., on or about August 29, 2018; and (5) 42 tablets of 1 mg lorazepam from S.R., M.D., on or about September 20, 2018.

119. On or about October 23, 2018, Patient D went to the emergency department at approximately 2:00 p.m. for shortness of breath, wheezing, and bilateral ankle swelling. At the hospital, Patient D appeared to be heavily sedated, even though her last dose of alprazolam was at

approximately 7:00 a.m. Patient D refused admission to the hospital and signed out against medical advice.

120. On or about November 16, 2018, Patient D saw D.H., M.D., to establish care. Patient D's current medications included Suboxone, suvorexant, sertraline, buspirone,[23] gabapentin,[24] and alprazolam. D.H., M.D., evaluated Patient D for opioid use disorder and determined that she had a 44-year history of severe opioid use disorder. Patient D told D.H., M.D., that she had been going to a treatment provider who told her she needed to discontinue taking alprazolam. D.H., M.D.'s plan was to continue Suboxone therapy, discontinue suvorexant, and prescribe trazodone.[25] D.H., M.D., talked with Patient D about the dangers of taking alprazolam and the possibility of switching benzodiazepine medications and tapering Patient D's daily use.

121. According to CURES, from on or about November 28, 2018 through May 31, 2019, D.H., M.D., prescribed Suboxone and/or Sublocade[26] to Patient D.

122. According to CURES, on or about November 30, 2018, Patient D filled a prescription written by A.R., D.D.S., for 20 tablets of 325-5 mg hydrocodone acetaminophen. On or about December 4, 2018, Patient D filled a prescription written by Respondent for 30 tablets of 20 mg suvorexant.

123. On or about November 30, 2016, Patient D saw D.H., M.D. Patient D's treatment plan was to discontinue alprazolam, start diazepam, and begin a tapering regimen.

124. On or about December 5, 2018, Patient D saw Respondent in his office. Patient D requested a prescription for alprazolam, which Respondent wrote. On or about the same day, Patient D filled that prescription for 30 tablets of 1 mg alprazolam.

125. From on or about December 15, 2018 to December 21, 2018, Patient D was hospitalized for acute hypoxic respiratory failure due to viral pneumonia.

126. On or about December 21, 2018, Patient D saw D.H., M.D. D.H., M.D., noted that Patient D kept falling asleep during her appointment. Patient D reported that at her last hospital

---

[23] Buspirone is used to treat anxiety.
[24] Gabapentin, brand name Neurontin, is a nerve pain medication.
[25] Trazodone is an anti-depressant and a sedative often used to treat insomnia.
[26] Sublocade, is the brand name for extended release buprenorphine injection.

visit, she did not tell her treatment providers that she was currently taking Suboxone until halfway through her visit, and that she had been taking extra Suboxone doses when she experienced cravings. D.H., M.D., noted that she wanted to start Patient D on Hepatitis C medications to possibly treat Patient D's sleepiness. D.H., M.D., noted that she would reach out to Respondent as Patient D's primary care provider (PCP) to order a sleep test.

127. On or about December 26, 2018, Respondent documented that he gave Patient D a prescription for 10 tablets of 1 mg alprazolam, which Patient D filled on or about the same day. According to CURES, on or about December 27, 2018, Patient D filled another prescription written by Respondent for 30 tablets of 20 mg suvorexant. Respondent's records fail to document this prescription.

128. On or about January 3, 2019, Patient D saw Respondent in his office. In his note for this visit, Respondent documented that he did not know why Patient D needed a neurology evaluation as suggested by the medication-assisted treatment clinic. He ordered a neurology referral and gave Patient D medication refills. According to CURES, on or about the same day, Patient D filled a prescription written by Respondent for 30 tablets of 1 mg alprazolam.

129. On or about January 8, 2019, Patient D saw D.H., M.D. Patient D told D.H., M.D., that she saw her PCP and that Respondent was "fumbled" about how many providers she was seeing and that he did not know she had so many health issues. Patient D also told D.H., M.D., that she liked Respondent because he gives her alprazolam prescriptions.

130. On or about January 22, 2019, Patient D saw D.H., M.D. Patient D had lost her housing and was living in a shelter. D.H., M.D., noted that she had tried to request medical records from Respondent but that he had not responded. D.H., M.D., encouraged Patient D to change to another PCP and advised her that she thought Patient D's daytime sleepiness was from benzodiazepine sedation.

131. On or about February 5, 2019, Patient D saw D.H., M.D. Patient D reported that she had not taken alprazolam for approximately 10 days, and that she always ran out of the medication early every month. Patient D told D.H., M.D., that she did not want to stop taking alprazolam and that she had an appointment with Respondent to get a medication refill. D.H.,

M.D., documented that she had been trying to get Respondent to do a work-up and treat Patient D's daytime sleepiness.

132. According to CURES, on or about February 5, 2019, Patient D filled a prescription written by Respondent for 30 tablets of 1 mg alprazolam.

133. On or about February 12, 2019, Patient D saw Respondent in his office. Patient D reported that her alprazolam tablets had been stolen at the shelter where she was living. Respondent gave Patient D another alprazolam prescription. According to CURES, Patient D filled a prescription written by Respondent for 30 tablets of 1 mg alprazolam on or about the same day.

134. On or about March 5, 2019, Patient D saw D.H., M.D., D.H., M.D., offered to take over Patient D's alprazolam prescriptions and start tapering down her use. Patient D declined.

135. According to CURES, on or about March 12, 2019, Patient D filled a prescription written by Respondent for 30 tablets of 1 mg alprazolam.

136. At a visit on or about March 19, 2019, D.H., M.D., documented that she told Patient D that she talked to Respondent about Patient D's recent hospitalization for aspirin overdose:

> I let [Patient D] know that I reviewed my concerns about her benzo use and this was the likely cause of her losing track of her aspirin intake and that [Respondent] had shared similar concerns and that he told me he didn't feel comfortable continuing to prescribe them for her.

D.H., M.D., also noted that Patient D was misusing benzodiazepines by taking more than prescribed and running out of medication early:

> Patient falls asleep in her visits and is taking medications without remembering that she took them because of sedation – likely the cause of her recent salicylate overdose. She has been unable to follow through on finding housing or looking for work. She uses benzos when driving and this may have contributed to her recent [motor vehicle] accident. Patient takes more than is prescribed despite attempting to take it as prescribed – she is unable to control her use. Patient meets DSM-V criteria for benzodiazepine use disorder but is unwilling to engage in treatment for it. Her PCP continues to prescribe her medications despite her clear use/misuse.

137. On or about March 27, 2019, D.H., M.D., advised Patient D to discontinue taking alprazolam. D.H., M.D., started prescribing diazepam to Patient D with the plan to taper Patient D's use. D.H., M.D., also started treating Patient D's Hepatitis C.

138. On or about April 1, 2019, April 8, 2019, and April 11, 2019, Respondent received notifications that Patient D had gone to the emergency department. The hospital records sent to Respondent indicated that Patient D had accidentally overdosed on or about April 11, 2019.

139. On or about April 15, 2019, Patient D saw Respondent in his office. Respondent failed to document any discussion with Patient D regarding her April 2019 hospitalizations. Respondent instead noted that Patient D's "psych" wanted to take over the alprazolam prescriptions. Patient D asked Respondent for another alprazolam refill. Respondent gave Patient D a prescription for 10 tablets of 1 mg alprazolam, which Patient D filled on or about April 15, 2019.

140. On or about April 17, 2019, Patient D was taken to the hospital following a car accident. Patient D complained of lumbar spine pain. Patient D was told to follow up with her PCP for any pain medications due to her chronic opiate maintenance therapy.

141. On or about April 23, 2019, Patient D returned to the hospital and complained of progressive back pain. Patient D asked for a Dilaudid injection. The hospital work-up showed mild diffuse lumbar tenderness with no major trauma. Hospital treatment providers gave her Flexeril.[27]

142. On or about April 24, 2019, Patient D saw Respondent in his office. Patient D asked for a physical therapy referral and pain medications. Respondent prescribed Advil as needed.

143. On or about April 25, 2019, Patient D saw D.H., M.D. D.H., M.D., told Patient C that her urine drug screen was positive for alprazolam. Patient D initially denied taking alprazolam, despite filling a prescription on or about April 15, 2019, then admitted she took some from a friend. D.H., M.D., noted that Patient D was not following the benzodiazepine protocol, and that she was taking more diazepam than prescribed and taking alprazolam illicitly.

144. On or about April 30, 2019, Patient D told D.H., M.D., that Respondent told her that he would no longer be giving her any more alprazolam prescriptions.

145. On or about July 2, 2019, Patient D saw Respondent in his office. Patient D requested gabapentin. Respondent documented that he refilled Patient D's medications.

[27] Flexeril, brand name for cyclobenzaprine, is a muscle relaxant.

146. On or about July 24, 2019, Patient D went to the emergency room. Patient D complained of abdominal pain and said she was taking antibiotics for a urinary tract infection (UTI). She was requesting a hydromorphone injection, which hospital treatment providers gave her. Patient D had no objective evidence showing that she had a UTI and her abdominal x-ray was normal.

147. On or about August 5, 2019, Patient D saw Respondent in his office. Respondent noted that Patient D needed medication refills and that he gave them to her. Respondent did not document any discussion with Patient D about her hospitalization on or about July 24, 2019, or treatment for a UTI.

148. On or about August 8, 2019, Patient D went to the emergency department. She complained of lower abdominal pain and urinary frequency. All of Patient D's diagnostic testing was normal. At the hospital, Patient D was given a morphine[28] injection, and upon discharge, was given a prescription for 10 tablets of 325-5 mg hydrocodone acetaminophen.

149. On or about August 9, 2019, August 24, 2019, and August 29, 2019, Respondent received notifications that Patient D had been treated in the emergency department the day prior.

150. According to CURES, on or about August 10, 2019, August 15, 2019, and August 28, 2019, Patient D filled prescriptions written by other treatment providers for 12 tablets of 325-5 mg hydrocodone acetaminophen, 6 tablets of 1 mg lorazepam, and 12 tablets of 325-5 mg hydrocodone acetaminophen.

151. According to CURES, on or about September 28, 2019, Patient D filled a prescription written by A.F., M.D. for 12 tablets of 325-5 mg hydrocodone acetaminophen. On or about October 28, 2019 and November 1, 2019, Patient D filled two prescriptions written by C.H., M.D., each for 20 tablets of 50 mg tramadol.

152. On or about October 31, 2019, Respondent wrote a letter to Patient D's psychiatrist. In the letter, Respondent said he was concerned about Patient D's psychiatric and mental ability to safely operate a car.

---

[28] Morphine is an opioid pain reliever and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d).

153. On or about November 2, 2019, Patient D went to the emergency department complaining of abdominal pain. Treatment providers at the hospital noted Patient D's prior visits for the same symptoms and determined that Patient D had been treated the day prior at another hospital for the same symptoms. Patient D was requesting intravenous pain medication. She was given Benadryl and Tylenol.

154. On or about November 7, 2019, Patient D saw Respondent in his office. Respondent failed to document any discussion with Patient D about her prior encounters at the emergency department. Patient D requested tramadol and Respondent wrote her a prescription for 30 tablets. On or about the same day, Patient D filled that prescription for 30 tablets of 50 mg tramadol.

155. On or about December 5, 2019, Patient D saw D.H., M.D. D.H., M.D., restarted Patient D on Suboxone therapy.

156. On or about February 13, 2020, Patient D went to the emergency department. She reported that she was having a severe IBS attack. Hospital treatment providers noted that Patient D was last in the emergency department on February 8, 2020 and had gone to another facility a few days prior to that. Patient D was given a prescription for 7 tablets of 325-5 mg hydrocodone acetaminophen and told to follow up with her PCP.

157. On or about February 20, 2020, Patient D returned to the emergency department. She again complained of an IBS flare up with pain in the lower left quadrant. Patient D also specifically requested intravenous hydromorphone. Hospital treatment providers told Patient D not to come to the hospital for chronic pain and gave her another prescription for 7 tablets of 325-5 mg hydrocodone acetaminophen.

158. On or about March 16, 2020, Patient D saw Respondent in his office. Respondent noted that Patient D was no longer seeing her psychiatrist. Patient D complained of anxiety and requested an alprazolam prescription until she set up care with a new psychiatrist. Respondent documented that he gave her an alprazolam prescription. However, according to CURES, on or about March 16, 2020, Patient D filled a prescription for 7 tablets of 1 mg lorazepam, not alprazolam.

///

159. On or about April 23, 2020, Patient D saw Respondent in his office. Patient D reported that she was being treated with Suboxone, which was not helpful. She told Respondent she was still trying to establish care with a psychiatrist and asked Respondent to write another alprazolam prescription. On or about the same day, Patient D filled a prescription written by Respondent for 30 tablets of 0.5 mg alprazolam.

160. On or about May 22, 2020, Patient D saw Respondent in his office. Respondent documented that Patient D needed a refill and was stable. According to CURES, on or about May 23, 2020, Patient D filled a prescription written by Respondent for 60 tablets of 0.5 mg alprazolam. Respondent failed to document why he doubled Patient D's alprazolam dose.

161. According to CURES, from on or about June 22, 2020 through August 20, 2021, Respondent continued to see Patient D and prescribe 60 tablets of 0.5 mg alprazolam on a monthly basis.

162. At a visit on or about March 15, 2021, Patient D told Respondent that she was willing to start tapering her alprazolam dose in order to get her driver's license back. Respondent failed to document any plan or protocol to taper Patient D's alprazolam use, and he still continued to prescribe Patient D the same amount.

163. Respondent committed gross negligence in his care and treatment of Patient D which includes, but is not limited to, the following:

a. Respondent failed to properly manage Patient D's treatment for anxiety.

SECOND CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

164. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 52943 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, and D, as more particularly alleged hereafter:

Patient A

165. Paragraphs 9 through 38 above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

166. Respondent committed repeated negligent acts in his care and treatment of Patient A which includes, but is not limited to, the following:

a. Respondent failed to adequately investigate Patient A's low back pain history via additional imaging and/or specialty consultations;

b. Respondent failed to offer Patient A non-opiate medications and creams;

c. Respondent failed to stress weight loss and daily exercise to reduce Patient A's pain;

d. Respondent failed to strongly recommend acupuncture, chiropractic manipulation, and/or physical therapy to reduce Patient A's methadone use;

e. Respondent failed to perform an independent assessment of Patient A's need for methadone therapy;

f. Respondent failed to perform a risk stratification analysis before prescribing methadone to Patient A;

g. Respondent failed to consult with addiction and/or pain management specialists when tapering Patient A's methadone use;

h. Respondent failed to monitor Patient A's compliance with her medication regimen by consulting CURES and/or ordering urine drug screens;

i. Respondent failed to offer Patient A naloxone therapy;

j. Respondent failed to obtain routine EKG monitoring while Patient A was on methadone therapy;

k. Respondent failed to maintain adequate and accurate documentation showing he monitored Patient A's medication compliance;

l. Respondent failed to document and/or perform an adequate anxiety evaluation before prescribing alprazolam to Patient A;

m. Respondent failed to treat Patient A's anxiety by trying other non-addictive medications;

n. Respondent failed to obtain a mental health consultation with regards to Patient A's anxiety;

o. Respondent prescribed to Patient A a combination of methadone and a benzodiazepine, risking accidental respiratory failure; and

p. Respondent failed to document that he discussed the risks, benefits, and alternatives of concurrent methadone and benzodiazepine therapy with Patient A and failed to obtain a signed pain contract agreement.

Patient B

167. Paragraphs 39 through 68 above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

168. Respondent committed repeated negligent acts in his care and treatment of Patient B which includes, but is not limited to, the following:

a. Respondent failed to perform an adequate diagnostic evaluation of Patient B's chronic ankle, neck and low back pain;

b. Respondent failed to offer other NSAIDs and/or safer non-opiate medications for Patient B's chronic pain management;

c. Respondent failed to offer chiropractic manipulation and/or acupuncture therapy for Patient B's chronic low back and neck pain;

d. Respondent failed to perform a risk stratification analysis before starting Patient B on long-term opiate therapy;

e. Respondent failed to recognize Patient B's high risks for opioid misuse;

f. Respondent failed to periodically monitor Patient B's opiate use via urine drug screens and/or review of CURES;

g. Respondent failed to offer Patient B multi-disciplinary management for her chronic pain;

h. Respondent failed to maintain adequate and accurate records of monitoring Patient B's opiate therapy;

i. Respondent failed to perform a comprehensive anxiety evaluation for General Anxiety Disorder (GAD);

///

j. Respondent failed to try selective serotonin reuptake inhibitor therapies to treat Patient B's GAD;

k. Respondent failed to refer Patient B to mental health specialists to manage Patient B's persistent and refractory anxiety;

l. Respondent failed to recognize Patient B's benzodiazepine dependency;

m. Respondent concurrently prescribed opiates and benzodiazepines to Patient B, putting Patient B at risk of respiratory depression and/or death;

n. Respondent failed to provide Patient B naloxone therapy to reduce the risk of respiratory failure due to concurrent opiate and benzodiazepine therapy; and

o. Respondent failed to document a discussion with Patient B regarding the risks of long-term opiate and benzodiazepine use or use a pain care agreement.

Patient C

169. Paragraphs 69 through 96 above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

170. Respondent committed repeated negligent acts in his care and treatment of Patient C which includes, but is not limited to, the following:

a. Respondent failed to document and/or perform an adequate evaluation of Patient C's chronic pain;

b. Respondent failed to offer Patient C safer and non-addictive medications to treat her chronic pain;

c. Respondent failed to recommend exercise and/or dietary modifications to Patient C to treat her chronic pain;

d. Respondent failed to consider and/or recommend chiropractic adjustment and/or acupuncture;

e. Respondent failed to refer Patient C to a mental health specialist for cognitive behavioral therapy to reduce Patient C's needs for high levels of methadone;

f. Respondent failed to perform an independent assessment of Patient C's need for methadone therapy;

g. Respondent failed to perform a risk stratification analysis before starting Patient C on long-term opiate therapy;

h. Respondent failed to monitor Patient C's opiate use through urine drug screens and/or review of CURES;

i. Respondent failed to obtain routine EKG monitoring of Patient C while on methadone therapy;

j. Respondent failed to start tapering Patient C's methadone use before 2019;

k. Respondent failed to maintain adequate and accurate records of monitoring Patient C's compliance with her medications;

l. Respondent failed to document and/or perform a detailed anxiety evaluation of Patient C prior to prescribing lorazepam;

m. Respondent failed to try prescribing safer non-addictive medications to Patient C to treat her anxiety;

n. Respondent failed to offer Patient C a mental health consultation to reduce her benzodiazepine use, given Patient C's dependency on high dose methadone;

o. Respondent concurrently prescribed Patient C a combination of opiates and benzodiazepines, putting Patient C at risk of respiratory depression and/or death; and

p. Respondent failed to document a discussion with Patient C regarding the risks of long-term opiate and benzodiazepine use.

Patient D

171. Paragraphs 97 through 163 above, are hereby incorporated by reference and re-alleged as if fully set forth herein.

172. Respondent committed repeated negligent acts in his care and treatment of Patient D which includes, but is not limited to, the following:

a. Respondent failed to properly document and/or evaluate Patient D's anxiety before prescribing alprazolam;

b. Respondent failed to try other non-addictive anxiolytic medications to treat Patient D's anxiety;

c. Respondent failed to refer Patient D to a mental health specialist to treat her persistent anxiety;

d. Respondent failed to cooperate and coordinate care with Patient D's addiction specialists;

e. Respondent resumed prescribing alprazolam to Patient D in 2020; and

f. Respondent, as Patient D's PCP, failed to properly address and treat for Patient D's chronic Hepatitis C infection.

THIRD CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate and Accurate Medical Records)

173. Respondent has further subjected his Physician's and Surgeon's Certificate No. G 52943 to disciplinary action under sections 2227 and 2234, as defined by section 2266 of the Code, in that he failed to maintain adequate and accurate records in his care and treatment of Patients A, B, C, and D, as more particularly alleged in paragraphs 9 through 172, above, which are hereby incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. G 52943, issued to Respondent Dominic Kam-Yin Ho, M.D.;

2. Revoking, suspending or denying approval of Respondent Dominic Kam-Yin Ho, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Dominic Kam-Yin Ho, M.D., to pay the costs of investigation and enforcement of this case and, if placed on probation, to pay the Board the costs of probation monitoring; and

///

///

///

///

4. Taking such other and further action as deemed necessary and proper.

DATED: FEB 0 3 2022

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SF2022400092
83229865.docx